MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: February Legislative & Regulatory Initiatives

Date: February 5, 2007

I am providing my analysis of nineteen (19) legislative and regulatory initiatives in anticipation of the February 7 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. H.B. No. 3 (Restroom Access)

This bill is almost identical to H.B. No. 329 introduced in the 143rd General Assembly on January 18, 2006. That bill remained in committee at the end of the last session.

The SCPD issued the following March 16, 2006 comments on the predecessor bill:

MEMORANDUM

DATE: *March 16, 2006*

TO: *All Members of the Delaware State Senate and House of Representatives*

FROM: *Ms. Daniese McMullin-Powell*
Chairperson
State Council for Persons with Disabilities

RE: *H.B. 329 [Restroom Access]*

The State Council for Persons with Disabilities (SCPD) has reviewed H.B. 329 which would require any retail establishment that has a toilet facility for its employees to allow a customer to use that facility during normal business hours if the following conditions are met: 1) the customer has an eligible medical condition or uses an ostomy device; 2) there are at least 3 employees working at the time of the request; 3) the retailer does not normally make its restroom available to the public; 4) the toilet facility is not located in an area where providing access would create an obvious health, safety, or security risk; and 5) there is no public restroom immediately accessible to the customer. Retailer and employee immunity is granted such that liability is

limited to the unlikely situation in which there is gross negligence resulting in customer injury or death. SCPD has the following observations.

First, the sponsors may wish to consider amending the definition of "retail establishment". At a minimum, the sponsors may wish to insert "or lease" after "sale" to cover establishments which lease vehicles, furniture, etc. Alternatively, the sponsors could consider some variation of the "place of public accommodation" definition in Title 6 Del.C.§4502(11), i.e., "any establishment which caters to or offers goods or services or facilities to, or solicits patronage from, the general public."

Second, the bill is unclear on what proof, if any, a retailer may request that a customer has a qualifying condition. The "any other medical condition that requires immediate access to a toilet facility" standard is fairly broad. The lack of standards may foster unnecessary confrontations and disagreements. Cf Thompson v. Dover Downs, Inc., No. 40, 2005 (Del. November 3, 2005) [reasonable inquiry permitted on status of "service dog"]. Moreover, the ADA may limit the scope of the retailer's inquiry about the person's disability. Id. at fn. 11. The sponsors could consider adding the following sentence to § 8902(2): "Any benefit of the doubt concerning the existence of an eligible medical condition shall be accorded to a customer who reasonably communicates his qualification."

Third, ADA regulations require places of public accommodation to modify practices when necessary to accommodate individuals with disabilities. See 28 C.F.R. §36.302(a). Under some circumstances, the ADA may already contemplate retailers waiving an employee-only restroom policy as an accommodation to a qualified individual with a disability. Moreover, municipalities could have ordinances granting greater rights. It would therefore be appropriate to insert the following new §8906:

> *§8906. Effect on other laws.*
>
> *Nothing in this chapter shall be construed to invalidate or limit any state, local, or other law providing persons with disabilities greater access to restrooms than required by this chapter.*

Fourth, the procedure for assessing a civil penalty is unclear. Query who is authorized to impose the penalty and what due process applies? Compare, e.g.,Title 16 Del.C.§§1109 and 7406B.

Thank you for your consideration and please contact SCPD if you have any questions regarding our observations on the proposed legislation.

cc: The Honorable Ruth Ann Minner
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council
Hb329 06-restroom access.doc

f:/pub/bjh/misc/housebillltr329

The new legislation, H.B. No. 3, differs from H.B. No. 329 in two respects. First, instead of covering stores with three or more employees, it only covers stores with ten or more employees. Second, first offenses result in a warning. A civil penalty is reserved for subsequent violations.

I view the March 16, 2006 observations as still apt. I recommend issuing a similar memo with three amendments. First, it should note the Council's previous review

and commentary on the predecessor bill in 2006, H.B. No. 329. Second, the summary of the bill should refer to the "10-employee" standard rather than the "3-employee" standard. Third, the Council could endorse the concept of the bill while noting it could be improved consistent with the above observations.

2. HCR No. 2 (State Children's Health Insurance Program)

Consistent with the attached article from the March edition of Consumer Reports, there are more than 8 million children without health insurance in the Nation. Another 4.4 million children are provided with health insurance through the federal State Children's Health Insurance Program ("SCHIP"). In Delaware, this initiative is known as the Delaware Healthy Children Program. It basically targets children of the "working poor" whose earnings exceed Medicaid eligibility levels but who lack dependant health insurance due to lack of employer coverage or inability to pay premiums. Unfortunately, the SCHIP program expires in September unless Congress votes to extend it beyond 2007.

HCR No. 2, which passed the House and Senate last month, requests Delaware's Congressional delegation to support SCHIP reauthorization. The SCPD's enabling legislation [Title 29 Del.C. §8734(b)] contemplates its provision of analyses and recommendations on federal legislation affecting persons with disabilities. I recommend that the Council reinforce HCR No. 2 with its own letter of support and that the Council encourage other disability-related agencies to do likewise. Time permitting, the Council could consider compiling a single letter endorsed by multiple agencies.

3. S.B. No. 6 (Delaware Health Insurance Pool)

This is an important bill. It is identical to S.B. No. 146 (with S.A. No. 1) which passed the Senate but not the House in the last legislative session. The Committee reviewed the predecessor bill in July, 2005 and both the SCPD and GACEC issued a strong endorsement of the concept of the legislation. See attached July 26, 2005 GACEC letter. For background on S.B. No. 146, see attached May 27 and July 5, 2005 News Journal articles and May 30, 2005 Capitol Review article. Background on S.B. No. 6 is included in the attached November 4, 2006, January 14, 2007, and February 2, 2007 News Journal articles.

The bill would create a State-subsidized insurance pool open to Delawareans who have resided in the State for at least 1 year (subject to $50,000 income cap) and employees of small businesses in which 30% of employees earn $33,000 or less. Some of these features are not specified in the bill itself but are discussed in the background articles. The State would provide reinsurance as an incentive for insurer participation. The State would cover 90% of any losses by any policyholder exceeding $30,000 for an individual or a family during a fiscal year. A 5-person board would be established to administer the pool and approve one or more insurers to implement the program. Two benefit packages would be required. Any insurer administering a health insurance plan for State employees (currently Blue Cross and Coventry) would be required to submit a good faith bid for the pool. There would ostensibly be no pre-existing condition

exclusions and there are limitations on reasons for termination. The program could benefit up to an estimated 36,000 persons. There is a fiscal note. Half year costs were estimated to require a $6 million fiscal note last year. Full year costs are estimated to require a fiscal note of $12 million to $13 million. The absence of those funds was the primary reason the predecessor bill failed in 2006. The attached February 2, 2007 article indicates that the Governor's budget includes $5 million for this initiative but such funding may be dependent upon raising the cigarette tax.

In the Fall of 2005, the DLP forwarded the attached October 18, 2005 letter to the Insurance Commissioner and sponsors questioning the legality of the two-year residency restriction. By inference, the letter may have prompted the amendment to the predecessor bill reducing the residency requirement to one year.

I recommend a strong endorsement of the bill subject to the following caveat. The Council would prefer deletion of the one-year residency limit in Section 8102(e) since it may be unenforceable under federal law. See, e.g., Shapiro v. Thompson, 394 U.S. 618 (1969) and Saenz v. Roe, 526 U.S. 489 (1999) [Constitutional right to travel disallows state provision of different benefits to otherwise eligible state residents based on the duration of their residency]. By analogy, other State programs subsidizing health care are open to residents irrespective of the duration of residency. Compare, e.g., Delaware Prescription Assistance Program (Title 16 Del.C. §3004B); Hearing Aid Loan Program (Title 16 Del.C. Ch. 26A and 16 Admin Code 4100); and Chronic Renal Disease Program (Title 29 Del.C. §§7932-7935 and 16 Admin Code 50000). This recommendation should be discussed since more liberal eligibility could potentially increase the fiscal note and jeopardize enactment of the underlying bill.

4. S.B. No. 11 (Delaware Prescription Drug Payment Assistance Program)

This bill was introduced on January 16, 2007. It remained in the Health & Social Services Committee as of January 31, 2007.

The Delaware Prescription Drug Payment Assistance Program (DPAP) subsidizes the cost of prescriptions for low income Delaware residents who are either elderly or SSDI beneficiaries. The bill has two effects.

First, it eliminates a prerequisite that applicants be ineligible for Nemours Health Clinic Pharmaceutical benefits since this program no longer exists.

Second, the current statute requires enrollment in Medicare D, if eligible. The bill adds an exception for persons who qualify for a Medicare D "Special Enrollment Period". Consistent with the attachments, HHS has established a Special Enrollment Period (SEP) available under a variety of circumstances outlined in the attached HHS chart published in January, 2007. See also attached January 3, 2007 HHS notice indicating that an enrollment request under the SEP would "take effect on the first day of the month after the enrollment election is made." The bottom line is that there are persons who have an extended "window" to apply for Medicare D or who have applied for Medicare D but whose enrollment is not yet effective. S.B. No. 11 would offer DPAP eligibility to such persons

I recommend endorsement.

5. H.S. No. 1 for H.B. No. 18 (Diploma Standards)

This bill was introduced on January 25 and passed the House the same day under a suspension of rules.

As background, there are currently 2 versions of Title 14 Del.C. §152, one effective until January 1, 2008 and one effective on January 1, 2008. See attachments. This bill has 2 effects.

First, it essentially defers the implementation of the version of §152 that would have taken effect in January, 2008 to January, 2011. This means that a standard diploma would still be issued to a student who does not achieve competency on the DSTP until January, 2011. The rationale for this change is that the DSTP is pending revision. This change favors students with disabilities who statistically perform poorly on the DSTP. It should result in more students with disabilities qualifying for a diploma in 2008-2010.

Second, it eliminates the "Delaware Distinguished Achievement Diploma" effective January 1, 2008. This change would ostensibly have little effect on students with disabilities.

I recommend endorsement.

6. H.B. No. 7 (School Bullying)

Various bills have been introduced in the past to deter bullying in schools. For example, in 2001, S.B. No. 237 was introduced to require districts to adopt comprehensive school safety policies incorporating anti-bullying components. That bill was laid on the table. In June, 2006, H.B. No. 483 was introduced. It passed the House but not the Senate. Background on that bill is contained in the attached June 6, 2006 Delaware State News article and June 7, 2006 News Journal article.

H.B. No. 7 is similar to the 2006 legislation, H.B. No. 483. H.B. No. 7 already passed the House with 2 amendments on January 21, 2007. As of January 31, it been reported out of committee in the Senate.

I have the following observations.

First, bullying is a pervasive problem which merits a comprehensive system of deterrence. For example, the attached April 26, 2001 Dialog article quotes statistics from the National Education Association estimating that 160,000 students miss school each day out of fear of being attacked or bullied and 10% of children who drop out of school do so because of repeated bullying. See also other attached publications describing bullying.

Second, the Department of Education adopted regulations in 2002 which require districts and charter schools to submit reports on bullying to the Department. See attached 14 DE Admin Code 601. In its comments on the regulations in 2002, the Council noted the anomaly inherent in requiring reporting of bullying while not requiring districts to affirmatively prohibit bullying.

Third, while the definition of "bullying" should be sufficiently broad to encompass a variety of forms (e.g. verbal, physical, sexual, and property threats), it must be tempered by the First Amendment. Consistent with the attached synopsis of Saxe v.State College Area School District, the Third Circuit struck down a Pennsylvania school district anti-harassment policy which defined harassment as "any unwelcome verbal, written or physical conduct which offends, denigrates or belittles an individual" because of characteristics including race, religion, gender, sexual orientation and disability. The definition of "bullying" in H.B. No. 7 may similarly be too broad. Soliciting embarrassment of a student [Section 4112D(a)(4)] could legitimately occur in a school election debate in which another candidate is criticized for his/her stance on a policy or practice.

Fourth, the definition of "bullying" should recognize that some playful teasing among children is normal. It should also account for sports-related interaction (e.g. a linebacker may be encouraged by coaches to place the other team's quarterback in reasonable fear of harm to his physical well-being). Cheerleaders may encourage their football team to "push 'em back, shove 'em back, way back" at a game or may otherwise verbally "denigrate" the opposing team at a pep rally. For these reasons, it would be preferable to narrow the scope of the definition in H.B. No. 7. For example, the DOE regulatory definition of "bullying" essentially limits it to a pattern or practice "over a period of time" so as not to "capture" incidental, isolated teasing or play activities. Requiring schools to report and punish most sarcastic or derogatory remarks made by students may simply be impractical.

Fifth, there is a minor grammatical error in Section 4112D(b)(E). The word "who" should be substituted for the word "that".

I recommend that the Council endorse the concept of the bill subject to narrowing the definition of "bullying" somewhat and correcting the grammatical error in Section 4112D(b)(E).

7. DMMA Indep. Plus Attendant Services Waiver Withdrawal [10 DE Reg. 1301 (2/1/07)]

_____This is an information item.

The Committee reviewed the proposed version of this initiative in December, 2006. At that time, no action was taken on the proposal based on the following analysis:

The Division of Medicaid and Medical Assistance submitted an application for an Attendant Services HCBS waiver to CMS on October 31, 2006. The Division has now published its solicitation of comments on the waiver.

As proposed, the waiver would include the following services: adult day care, respite, emergency response system, personal care services, attendant services, fiscal agent, support broker, and case management. Definitions of these services are provided in Appendix C. Services would be provided consistent with individual service plans. Participants would have the option of self-directing services. Participants would have to meet a nursing home standard of care. The effective date is July 1, 2007.

Representatives of the DDC, SCPD, DMMA, and I met on Friday, December 8, to discuss concerns with the waiver. Independence Plus waivers use an individual cap on services roughly equal to the average cost of nursing home care (approximately $5,900 monthly). Approximately $1,000 is earmarked for administrative supports (e.g. fiscal agent and support broker) irrespective of the extent of use of such supports. This leaves approximately $4,900 for other services. This would be insufficient to meet the needs of persons for some combination of extensive personal care and attendant services. In contrast, the existing E&D waiver uses an aggregate cap in which costs of "high end" users are offset by "low end" users. Thus, the group determined that it would be more beneficial to have individuals enroll in the E&D waiver supplemented by a non-Medicaid attendant services program. DMMA therefore plans to withdraw the attendant services waiver and support increased funding (e.g. through Tobacco funds) for attendant services. Given this development, commentary on the actual waiver is moot. I recommend no action.

As an update, the Tobacco Committee subsequently approved inclusion of sufficient funds to eliminate the waiting list for the attendant services program. DMMA has now formally issued notice of withdrawal of the Independent Plus Waiver application with the following comment:

> Eligible clients will continue to be placed in the State's Attendant Services Program. This option offers more services to the client population than would be available under th Waiver.

I recommend no further action apart from submission of testimony in support of this use of Tobacco Committee funds in the DHSS JFC hearings.

8. Dept. Of Insurance Final Medicare Supplement Insurance Regs. [10 DE Reg. 1307 (2/1/07)]

_____This is an information item.

> The SCPD commented on the proposed version of these regulations in November, 2006.

As background, a typographical error in 2004 regulations inadvertently eliminated a requirement that insurers offering Medicare Supplement Insurance make Plans A, B, C and F available. The Department proposed to correct the error. The Council endorsed the remedial regulations. The Department has now acknowledged the endorsement and adopted the regulations in the form proposed in November.

I recommend no further action.

9. DMMA Final Special Needs Trust Regulation [10 DE Reg. 1302 (2/1/07)]

The SCPD commented on the proposed version of these regulations in December, 2006. In a nutshell, the Council endorsed two amendments while recommending a substitute for the third amendment. DMMA has now adopted final regulations with no changes.

The Council had suggested that the Medical Review Team continue to review whether non-SSI and non-SSDI beneficiaries meet medical SSI standards. DMMA responds that another regulation [attached §20350.10.2] covers this situation. In pertinent part, it recites as follows:

> If the individual is not receiving these (SSI/SSDI) benefits, a separate disability determination must be made. The individual who is claiming the disability must submit acceptable medical evidence he has been determined disabled according to the standards used by the SSI program (Title XVI). The individual will be given a reasonable amount of time to provide the medical evidence.

There are pros and cons to this approach. One disadvantage is that it presupposes that all applicants will have the cognitive and financial wherewithal to compile documentation of medical disability meeting complex SSI standards. A second disadvantage is that the regulation uses passive voice and does not identify who within DMMA assesses the sufficiency of the medical documentation. Perhaps it is simply a benefits worker with no medical credentials. On the other hand, the removal of the Medical Review Team from the decision-making process, to the extent it is characterized as a conservative or constrictive body, could favor consumers.

I recommend no further action.

10. DMMA Prop. Final Institutionalized Spouse Reg. [10 DE Reg. 1220 (2/1/07)]

In April, 2006, DMMA adopted regulations adding illustrations to institutionalized spouse standards. Although comments were not solicited, the SCPD objected to characterizing any spouse receiving HCBS as an "institutionalized spouse" which would remove spousal impoverishment protections. When DMMA declined to adopt any amendments, the SCPD solicited review by CMS. CMS then influenced DMMA to agree to delete the illustrations. See August 17, 2006 letter accompanying the January P&L memo. DMMA then issued new regulations omitting the illustrations. However, the regulatory text still eliminated spousal impoverishment protections if a community spouse were receiving HCBS. Once again, the SCPD solicited CMS review. CMS responded with a December 21, 2006 letter (appended to January P&L memo) to the SCPD. CMS confirmed that it had advised DMMA of its concurrence with the Council's interpretation. DMMA has now published a conforming proposed regulation. The amendment allows a non-institutionalized spouse participating in an HCBS waiver to benefit from spousal impoverishment protections.

I recommend endorsement.

11. DMMA Proposed LTC Savings Bond Regulation [10 DE Reg. 1219 (2/1/07)]

The Division of Medicaid and Medical Assistance proposes to modify its treatment of U.S. Savings Bonds as countable resources for purposes of Medicaid long-term care eligibility.

As background, U.S. Savings Bonds generally have either an initial 6 month or 12 month "retention" period after purchase during which they cannot be redeemed. The only exception is for the owner to request a hardship redemption from the Office of Public Debt. The current regulation states that the bonds are not countable resources during the retention period but, if a hardship redemption is requested and granted, the U.S. Treasury check is counted as a resource.

I have the following observations.

First, the Summary of the Proposed Change is fraught with errors and would have benefitted from proofreading prior to publication. See references to "calrifying", "submitter", "avaailable", "valluation", and "ubless".

Second, the text of the regulations may not achieve the intent as reflected in the Summary. The Summary characterizes Savings Bonds as an available resource upon purchase unless a waiver of the retention period is requested and denied. The text retains the provision that the "(bonds) are not resources during the retention period." This is ostensibly contradicted later with the addition of "(s)ince bonds are redeemable due to hardship, the redemption value is treated as an available resource."

Third, a number of state Medicaid agencies have been adjusting their treatment of U.S. Savings Bonds. The attached Vermont materials compile both objections to treating Savings Bonds are resources upon purchase (including inconsistency with SSA POMS) and Vermont's agreement that the Bond should not be counted as a resource while the waiver request is pending. The Delaware regulation is unclear in this respect.

Fourth, a number of states also include a "grandfather" provision for existing Savings Bonds. For example, Vermont adopted its regulation effective December 1, 2004 with the following exclusion:

> Savings bonds purchased before June 15, 2004 that have their minimum retention period expire after that date continue to be an excluded resource if they are not redeemed, exchanged, surrendered, reissued or otherwise become available.

I recommend that the Council share the above observations with DMMA. The "bottom line" is that the Council would prefer: 1) abandonment of this initiative based on the SSA POMS approach (Savings Bonds are not resources during retention period); but 2) if adopted, consistency among the standards and inclusion of a "grandfather" provision akin to the Vermont standard.

12. DMMA Prop. LTC Life Estate and Promissory Note Regulations [10 DE Reg. 1216 (2/1/07)]

The Division of Medicaid & Medical Assistance proposes to change its Long Term Care Medicaid standards in two contexts: 1) treatment of life estates; and 2) treatment of purchases of promissory notes, loans, and mortgages. The changes are prompted by the attached Section 6016 of the Deficit Reduction Act of 2005.

I have the following observations.

First, in Section 20320.2.2.2, the last sentence should include, after "addition,", the words and punctuation "effective 4/1/06". See similar caveat in Section 20320.2.2 and DRA Section 6016(e).

Second, in Section 20320.2.2, last sentence, DMMA may wish to substitute "provided" for "providing".

Third, in Section 20330.3, second bullet, substitute "of" for "or" after the word "deferral".

Fourth, Section 20330.3, third paragraph, is structurally flawed. It recites that "DMMA will use the outstanding principal balance in determining resources unless the individual submits within 30 days the following information:" The "following information" section is then deleted in its entirety. I recommend retention of the current Pars. "a" and "b" and retention of the "strike out" language in the second paragraph. For example, an applicant may hold a note from an individual or firm that has filed bankruptcy or have a mortgage on real estate which has been condemned or been destroyed. The applicant should be allowed to demonstrate that the "principal balance" is not an accurate reflection of the true value of the note, mortgage, or other instrument.

I recommend sharing the above observations with the DMMA.

13. DOE Proposed Driver Education Regulation [10 DE Reg. 1205 (2/1/07)]

The Department of Education proposes to amend its driver education standards. The SCPD and GACEC submitted comments on the existing standards in August and October of 2002. The overall regulations therefore incorporate several provisions addressing students with disabilities.

The latest proposal is essentially a "housekeeping" measure. It updates a reference to the DOE associate responsible for driver education, substitutes "10^{th} grade" for "sophomore", and cross references the statewide curriculum for driver education. These are simply technical amendments..

I recommend endorsement.

14. DOE Proposed Content Standards Regulations [10 DE Reg. 1202 (2/1/07)]

The Department of Education proposes to adopt some discrete amendments to its standards covering district alignment of curriculum to State content standards. The changes are technical in nature. Grade clusters are modified in Section 6.0. The criteria for assessing alignment of district curricula to the State content standards are also modified in Section 6.0

I did not identify any inconsistencies or concerns with the proposal with one exception. The regulations only cover school districts and not charter schools. See title and Sections 1.0, 3.0, 4.0, 5.0, 6.0, 7.0, and 8.0. In contrast, other regulations and guidance ostensibly contemplate alignment of charter school curriculum with State content standards. See, e.g., attached excerpt from DOE's Delaware Charter Schools, Frequently Asked Questions (April, 2006):

> 13) Are charter schools held to the same content standards and accountability requirements as other public schools in the State of Delaware?
>
> Yes. As public schools, charter schools are required to address the state content standards in their instructional programs and administer the same state assessments as all other public schools. Charter schools are held to the same accountability requirements as other public schools.

This view is generally reinforced in other DOE regulations, including 14 DE Admin Code 101, §§1.0 and 2.0 (charter schools participate in DSTP which is an assessment of performance relative to State content standards); 14 DE Admin Code 103, §1.0 (charter schools subject to accountability system); and 14 DE Admin Code 104, §1.0 (charter schools participate in Delaware Public Education Profile system which includes compilation of achievement results in each content area).

I recommend that the Council share the above observations with the DOE and SBE.

15. DOE Proposed Salary Supplement Regulations [10 DE Reg 1208 (2/1/06)]

The Department proposes to adopt some discrete amendments to its standards covering salary supplements. Title 14 Del.C. §1305 authorizes supplements to base salaries based on multiple criteria, including achieving certification from the National Board for Professional Teaching Standards, accepting additional responsibility assignments that impact student achievement, and completion of specific professional development training.

The changes are predominantly technical in nature. I did not identify any inconsistencies or concerns with the proposed standards.

Given the weak special education nexus, and lack of identification of concerns, I recommend no action.

16. DOE Proposed Standard Certificate Regulations [10 DE Reg. 1213 (2/1/06)]

The Department proposes to adopt some discrete amendments to its Standard Certificate regulations. The stated purpose is "to expand the provision for the Department's ability to not act on an application for certification if the applicant is under an official investigation."

I have the following observations.

First, the sections being modified (§§3.3.1 and 6.3) have been the subject of prior SCPD and GACEC commentary. The Councils previously suggested that the DOE consider deletion of the reference to "immorality". The DOE responded that the Delaware Code authorizes consideration of "immorality" in connection with educator certification and employment. See, e.g., Title 14 Del.C. §§1218, 1411, and 1420. I would not recommend revisiting this aspect of the regulations.

Second, in Section 6.3, the DOE may wish to delete the following reference: "(i.e., 14 DE Admin Code, Ch. 15 et al)". The intent of the sentence in which this reference appears is to be very broad. By including a provision which literally means "that is", the DOE actually limits the scope of the standard. If it were retained, the DOE could consider substituting "e.g." (for example) since this would not be as limiting. Another option would be to substitute "(including 14 DE Admin Code Ch. 15)".

I recommend sharing the above minor recommendation with the DOE, SBE, and Professional Standards Board.

17. Dept. Of Insurance MCO Appeal Regulations [10 DE Reg. 1233 (2/1/07)]

The Department of Insurance proposes to adopt a wholesale revision of its regulations covering review and appeal of MCO decisions. The impetus for the new regulations is S.B. No. 295 which was signed by the Governor on July 6, 2006. S.B. No. 295 transferred regulatory authority over HMOs/MCOs previously vested in DHSS in the Department of Insurance. The legislation is comprehensive and prescriptive in scope and the regulations mirror this scope and detail.

As background, the regulations cover State-regulated MCOs. They address multiple methods for an insured to question the decision of an MCO. First, MCOs must offer an "internal review process" (IRP). If an insured receives an adverse decision from the IRP, this is known as a "final coverage decision". The insured can then seek further review through either: 1) mediation (§4.0); or 2) arbitration (§6.0)(for denials of emergency care services or denials not based on lack of medical necessity) or external review (§8.0) by an independent utilization review organization (IURO) (for denials based on medical necessity or appropriateness of services). If there are mixed bases underlying a denial of a claim, review by an IURO is favored. See §5.3.1. The Delaware Code authorizes the MCO to appeal an adverse IHCAP decision to the Superior Court. See Title 18 Del.C. §6415(b).

I have the following observations.

First, the insured can assign a claim to a health care provider who can then pursue "appeals" with the insurer. See definition of "authorized representative" in Section 2.0. This is similar in effect to H.B. No. 438 which passed the House but not the Senate in 2006. The SCPD endorsed that bill.

Second, in Section 2.0, the definition of "health care service" could be improved. It covers "services and supplies". This may not cover denials of durable medical equipment (DME) or assistive technology (e.g. nebulizer, hearing aid, wheelchair; AAC device). Cf. reference to "products" in definition of "medical necessity" in Section 2.0. The Legislature contemplated reviews of denials of "devices". See reference to "device" in Title 18 Del.C. §6417(c)(3)e (as amended by S.B. No. 295). The Dept. Of Insurance should consider inclusion of references to both DME and AT (defined at 29 U.S.C. §3002).

Third, in Section 2.0, the definition of IHCAP omits the term "reduction" which is explicitly included in the definition of "adverse determination". It should be included for consistency.

Fourth, in Section 2.0, the definition of "medical necessity" should be amended to include "disability" and "condition". There are health conditions (e.g. cerebral palsy; pregnancy) that may require medical services but are not diseases or illnesses. Compare definition of "health care services" in Section 2.0 which includes a reference to "disability". See also reference to "disability" in definition of "health care services" in Title 18 Del.C. §6403(d) (as amended by S.B. No. 295). Cf. reference to "condition" in Section 9.1.

Fifth, although the list of professionals within the definition of "provider" in Section 2.0 is not exclusive, it would be preferable to include some mental health related practitioners who are commonly included in health care networks (e.g. licensed psychologist; LCSW).

Sixth, Section 3.1.1 could be improved by substituting 12 point type for 11 point type.

Seventh, Section 3.1.2 could be improved by proscribing use of italicized type which is generally more difficult to read than "block" styles.

Eighth, the regulations do not address maintenance of services during the pendency of reviews and appeals. This is generally viewed as a matter of basic due process.
Compare 16 DE Admin Code 5100, §5308; 42 C.F.R. §431.231.230 (Medicaid); and Title 14 Del.C. §3143. At a minimum, the regulations could require continuation of services during expedited reviews of imminent and serious threats within the purview of Section 9.1. The discontinuation of such services could be life-threatening.

Ninth, coverage of Medicaid MCOs is unclear. Section 5.5 suggests that the arbitration and IHCAP systems do not apply to Medicaid MCOs. Based on "inclusio

unius, exclusio alterius", this would suggest that mediation in Section 4.0 is available to review Medicaid MCO disputes. This should be clarified. Parenthetically, H.B. No. 295 did not exclude Medicaid MCOs from its scope [Title 18 Del.C. §6403(e)] and it would be preferable to apply the consumer protections in the regulations to Medicaid MCOs unless they actually conflict with Medicaid protections. For example, a mediation system could supplement and not supplant a right to a Medicaid administrative hearing.

Tenth, it would be preferable to include an authorization for an "in forma pauperis" application to waive (in whole or part) the $75 fee for arbitration otherwise required by Section 6.1.3.3. There may be indigent consumers who will lack the financial wherewithal to pay $75 to contest an insurance denial. The Department would then have to determine whether the $75 fee would be waived or imposed on the insurer. See Section 6.7.1. By analogy, the insurer pays all costs of an IHCAP review. See Section 11.1.

Eleventh, Sections 14.1 and 14.2 protect a "covered person" and "provider" from retaliation. It would be preferable to also include the covered person's employer if there is an employer-based group policy. Otherwise, the insurer could retaliate against the employer (e.g. through non-renewal of policy).

I recommend that the above observations be shared with the Department of Insurance.

18. Dept. of Insurance MCO Certification & Operations Regs. [10 DE Reg. 1249 (2/1/07)]

The Department of Insurance proposes to adopt new standards covering MCO eligibility for a certificate of authority and operation of the MCO's system. The changes are prompted by enactment of S.B. No. 295 in 2006.

I have the following observations.

First, the definition of "health care service" in Section 2.0 is somewhat narrower than the same definition in proposed Regulation 1301. Although the statute refers to "physical disability" [Title 18 Del.C. §6403(d)], this is unnecessarily limiting. The word "physical" should be deleted to obviate the exclusion of mental health services from the definition. The definition could also be improved by including a reference to supplies and equipment. The comparable definition in proposed Regulation 1301 covers "supplies". Moreover, it would be preferable to explicitly refer to durable medical equipment (DME) or assistive technology (e.g. nebulizer, hearing aid, wheelchair; AAC device). See second comment on proposed Regulation 1301. Cf. Reference to "products" in Section 8.2.8.3.

Second, the definition of "medical necessity" in Section 2.0 should be amended to include "disability" and "condition". There are health conditions (e.g. cerebral palsy; pregnancy) that may require medical services but are not diseases or illnesses. Compare definition of "health care services" in Section 2.0 which includes a reference to

"disability". See also reference to "disability" in definition of "health care services" in Title 18 Del.C. §6403(d) (as amended by S.B. No. 295).

Third, Sections 8.2.8.9 and 8.2.8.10 require notice to enrollees of the availability of grievances, arbitration, and the IHCAP system. The Department may also wish to include a reference to "mediation". See proposed Regulation 1301, §4.0.

Fourth, in Section 10, it would be preferable to also prohibit penalizing an enrollee and enrollee's employer (participating in a group plan) for critical reporting to State authorities.

Fifth, consistent with the comment in the "First" paragraph above, Section 11.4.6.5 literally would not cover denials of supplies or equipment unless the definition of "services" is expanded.

I recommend that the above observations be shared with the Department of Insurance.

19. DPH Proposed Personal Assistance Services Agencies Regulations (Pre-publication)

In September, 2006, the Committee submitted comments on an initial draft of Division of Public Health regulations covering personal assistance services agencies. In January, DPH forwarded a significantly revised set of regulations to the SCPD and scheduled a meeting on January 30 to obtain input. I forwarded the memo (reproduced below) to Kyle on January 25. Kyle then shared the document as an "informal" set of comments subject to Policy & Law Committee review at its February meeting. I recommend formal endorsement of the January 25 memo.

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian Hartman

Re: Revised Proposed DPH Personal Assistance Services Agencies Regulations

Date: January 25, 2007

I am providing the following analysis of DPH proposed regulations forwarded by Kyle on January 23.

As background, I shared a 32-paragraph critique of the initial version of the regulations with the P&L Committee in September, 2006. The new version is a significant improvement over the September draft. It incorporates many, but not all, of the Committee's recommendations.

I have the following comments on the latest draft. Comments which are repeated from the September compilation are earmarked with an asterisk (*).

1*. In Section 1.1, the scope of services qualifying under the definitions of "companion" and "homemaker" are almost identical. Both definitions encompass housekeeping, cooking/meal preparation, and shopping/errands. Companion services and homemaker services are treated as distinct categories under the definition of "direct care worker". It would be preferable to adopt definitions clarifying distinctions between these categories.

2*. Some personal assistance agencies (e.g. Comfort Keepers) include transportation (e.g. to store; medical appointment) within their menu of services. DPH should include this as an authorized service under one or more of the definitions in Section 1.1 (e.g homemaker; companion; personal assistance). Section 5.1.4.1 requires the agency to include "transportation" within its personal assistance agreement with the consumer. It is inconsistent to treat transportation as a personal assistance service to be included in the agreement while omitting it from the definition section as a covered service. Finally, the definition of "personal assistance services" is strict, i.e., "services are limited" to a defined list. Omission of any reference to transportation means that it cannot qualify as a personal assistance service.

3. The definition of "homemaker" in Section 1.1 could be improved. It is inconsistent to state that it exclusively covers services within a residence and then provide an example (shopping) which requires an out-of-residence service. The definition of "companion" is less strict since it encompasses services provided "primarily", but not exclusively, within a residence.

4*. In Section 1.1, definition of "licensee", DPH should consider substituting "legal" for "public". There is a definition of "legal entity" and, I suspect, there will be few governmental (a/k/a public) personal assistance agencies. This would also conform to use of the term "legal entity" in the definition of "owner".

5*. The definition of "personal assistance services", first sentence, would benefit from insertion of "for compensation" after "services". Otherwise the "sweep" of the standards is too broad and would encompass a church sending volunteers to help an elderly parishioner, the Boy or Girl Scouts sending scouts to help with yard work/housecleaning, or agencies sending volunteers for clean-up assistance after a natural disaster. Alternatively, "volunteer" agencies could be excluded from licensure in Section 2.9.

6. Section 2.2.2.8 limits training, even continuing education training, to "in-house" instruction. This may be too limiting. Why require training to be "in-house"?

7. In Section 2.2.2, it would be preferable to add the following to the list: “Proof of insurance and bonding required by Section 7.0.” This is an important consumer protection and proof of coverage should be submitted to DHSS.

8. In Section 2.3.2.5.2, it would be preferable to substitute “plan of correction” for “detailed plan”. There is a definition of “plan of correction” and it may or may not be “detailed”.

9. In Section 2.4.1.1, delete the word “of”.

10. In Section 2.4.2.7.2.2, it would be preferable to insert “agents” between “affiliates” and “employee(s). This would “capture” violations by contractors.

11. In Section 2.4, there are explicit due process protections applicable to some disciplinary sanctions. For example, suspensions and revocations of licenses require notice (Section 2.4.3.1) and opportunity for hearing (Section 2.4.3.1.3). However, it is unclear what due process is available in other disciplinary contexts. For example, if the Department imposes an administrative penalty under Section 2.4.2.7.1, is there advance notice and right to a hearing? The availability of due process is likewise unclear for other sanctions (e.g. placement on provisional status accompanied by suspension of all admissions; refusal to renew license; refusal to issue initial license).

12. The term “admissions” in Section 2.4.2.4.3 is an “institutional” term. Standing alone, it may lead to confusion. Does it mean that an agency would not accept new consumer clients? Does it mean that an agency would suspend services to even existing clients? Since Section 5.0 clarifies the use of the term “admission”, it would be preferable to at least amend Section 2.4.2.4.3 to read as follows: “Suspend new intake and admissions within the purview of Section 5.0.”

13. In Section 2.4.4.1, first sentence, consider the following revision: “In the event the Department identifies activities which the Department determines present an immediate or imminent danger...”

Deleted: alleges matters

Deleted: ing

14. Section 2.7.1 contemplates “periodic” inspections by DHSS. It would be preferable to include an “outside” timetable. Since licensing is annual, an annual inspection should be the minimum. The Section could then be amended to read as follows: “A representative of the Department shall conduct at least annual inspections of every personal assistance services agency...”

15. Section 4.1.2. has a plural pronoun (their) with a singular antecedent (director). Consider substituting “the director’s” for “their”.

16. Sections 4.4.1, 4.4.2, and 4.5.1 contain references to “companions” and “homemakers” which are redundant. These terms are encompassed within the definition of “direct care worker”.

17. In Section 4.4.2.4, consider substituting “and” for “or” such that consumer satisfaction surveys are required, not optional.

18. In Section 4.4.2.6.6, there is a plural pronoun (their) with a singular antecedent (individual). Consider substituting “Individuals” for “Any individual”.

19*. Section 4.5 could be improved by including orientation to common assistive technology. Other regulations contemplate familiarity with some basic AT. See, e.g., Sections 5.4.5.1 and 5.4.6.

20. Section 4.5 could also benefit from inclusion of shopping-related financial documentation since shopping and running errands are included among personal assistance services. How should purchases and receipts be recorded? Should only cash transactions be done? Each agency must have “tight” policies and training in this context.

21. In Section 5.1.2, there is a plural pronoun (their) with a singular antecedent (consumer). Consider substituting “the consumer’s” for “their”.

22. There is some “tension” between Section 5.1.3 and Section 7.0. Literally, Section 5.1.3 would authorize an agency to forego liability insurance while Section 7.0 would require it. It should be required.

23. Section 5.2.3 contemplates “a description” of a consumer’s mental and physical status in an initial home visit. At a minimum, consider substituting “an itemized, written description”. My impression is that most agencies use a multi-item form or checklist. It would be preferable to encourage some itemization rather than allowing agencies to simply “eyeball” a consumer and provide a few conclusory statements.

24. In Section 5.2.6, consider inserting “results of” between “The” and “initial”.

25. In Section 5.3, it would be preferable to include a “reminder”, based on the definition of “service plan”, that it should include the scope, frequency, and duration of services. Perhaps a Section 5.3.4 could be added as follows: “The service plan shall include the scope, frequency, and duration of services.”

26. Sections 5.4.1.3 disallows a worker from applying a prescription skin cream or ointment. This is overbroad. Such care is authorized by Title 24 Del.C. Section 1921(19) which is incorporated into the scope of allowable services in the definition of “direct care worker”. For example, an elderly consumer may have a prescribed skin cream but be unable to reach a part of his body (e.g. back of head; feet). That consumer can delegate the application of the prescription cream to that area of the body by an unlicensed individual. Moreover, the regulation also disallows application of even non-prescription “therapeutic” creams and ointments (e.g. Neosporin; Cortaid for sunburn). This is likewise overbroad.

27*. Section 5.4.9 is similarly overbroad. Title 24 Del.C. Section 1921(19) authorizes a consumer to delegate the opening of a prescription container and assistance in taking the

medication to an unlicensed person. Completion of a Board approved medication training program is not required.

28. Section 5.5 would benefit from adding the following to the list of documents: "consumer satisfaction survey results".

29. In Section 5.5.2, DPH may wish to consider requiring that the consumer's signature be included on the activity logs. My impression is that most agencies require a consumer "sign-off" or acknowledgment of receipt of itemized services as a matter of practice. This reduces prospects for disputes over services.
30. Section 5.5.12.3.1 allows an agency 30 calendar days to submit a report on a "major adverse incident", including unexpected death. This is too long and would compromise any State investigation of negligence.

31. Section 5.6.1 includes a plural pronoun (their) with a singular antecedent (consumer). Consider substituting "the consumer's" for "their".

32*. In Section 5.6.3, it would be preferable to require 30 days notice prior to discharge rather than 2 weeks. Compare Title 16 Del.C. Section 1121(18). It may be very difficult for a consumer to obtain an alternate agency services plan within 2 weeks.

33. Section 5.6.3.2 authorizes a provider to discontinue services immediately upon its unilateral determination that the consumer should have a higher level of care. No notice would be required, leaving the consumer at great risk. In 2006, an assisted living agency unilaterally determined that a consumer (D.R.) exceeded the assisted living level of care and unilaterally terminated her services. The Division of Long-term Care Residents Protection conducted its own evaluation, determined the consumer eligible for assisted living services, and fined the provider who refused to reinstate services. Agencies make mistakes. Indeed, mistakes may be common in this context since the regulations allow the agency to make the level of care decision through persons with no credentials whatsoever. See Sections 5.2.1 and 5.3.1. If DPH allows abrupt, unilateral termination of services with no notice, this will create a huge "loophole" for agencies who simply want to stop services with no notice. Moreover, if a consumer has decompensated to the point of needing more care, an orderly transition period to a higher level provider would be more logical than complete termination of all services. The DPH approach would be akin to a nursing home determining that a resident needs a hospital level of care and abruptly discharging the resident to the street!

34. The exception of notice for non-cooperation or non-payment of charges (Section 5.6.3.3) is also highly objectionable. Contrast Title 16 Del.C. Section 1121(18), requiring 30 day notice of termination from long-term care facility even for non-payment. Similarly, dispensing with notice "when service goals have been met" is subjective and objectionable. I recommend adoption of a 30 day notice period and deletion of all exceptions (Sections 5.6.3.1-5.6.3.4) but for "emergency situations", akin to Title 16 Del.C. Section 1121(18). Apart from notice, I also recommend some authorization for consumer appeal of the decision.

35. In Section 7.0, DPH may wish to consider requiring that the insurance policy include a provision requiring notice to DHSS upon termination of the policy. For example,

mortgagees routinely require homeowner policies to include such a notice. Otherwise, DPH may not know that a struggling agency's insurance has lapsed.

I recommend that the above observations and recommendations be shared with DPH.

Attachments
A: 207back
F:pub/bjh/legis/07p&l/207bils